

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02948
Item 18-21 Film 212 3-22-57 et										181
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH o. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Home) Churchville Road					d. STREET ADDRESS Churchville Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle FLOYD Last ABSHER					4. DATE OF DEATH Month March Day 17 Year 19 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 3, 1903		9. AGE (In years last birthday) 55 54 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			10b. KIND OF BUSINESS OR INDUSTRY Own Shop		11. BIRTHPLACE (State or foreign country) Sparta N.C.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Joseph Absher					14. MOTHER'S MAIDEN NAME Mattie Toliver					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-32-3085		17. INFORMANT Address Mary Absher Havre De Grace 458 Franklin St.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.0 BLUE TOX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Alcoholism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.0										INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in pool of water while intoxicated							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pool at rear of house Aberdeen Harford Md.		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Paul F. Guerin, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 3/18/57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Sparta Cem.			22d. LOCATION (City, town, or county) (State) Sparta N.C.			
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson, Rising Sun					ADDRESS Rising Sun		24a. REC'D BY REGISTRAR 20 1957		24b. REGISTRAR'S SIGNATURE Nellie Perry	

STATE OF NEW YORK - ALBANY MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John	
Sex		Male	
Race		White	
Age		55	
Date of Death		March 20, 1957	
Place of Death		Albany, New York	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		Paul E. Overlin, M.D.	

BUREAU T. M.

MAR 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02969 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02949

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELAIR</u> c. LENGTH OF STAY IN 1b <u>-</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MD Route 136</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Havre de Grace</u> d. STREET ADDRESS <u>RD 1 Box 19</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry Vernon Baker</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 29, 1926</u> 9. AGE (In years last birthday) <u>30</u> yrs.		4. DATE OF DEATH <u>March 3</u> 19 <u>57</u> Month Day Year IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry M. Baker</u> 14. MOTHER'S MAIDEN NAME <u>Rhoda Victoria Keithley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. #2</u> 16. SOCIAL SECURITY NO. <u>217-20-1155</u> 17. INFORMANT <u>Mrs. Rhoda V. Baker</u> Address <u>R.D. 1 Box 19 Havre de Grace, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury chest</u> DUE TO (b) <u>816X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subcutaneous emphysema face, chest abdomen</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto auto type</u> 20c. TIME OF INJURY Month, Day, Year <u>March 3 1957</u> Hour o. m. <u>1230</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 136</u> 20f. (City or town) (County) (State) <u>Bel Air Harford Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u> <u>Bel Air, Md.</u>		DATE SIGNED <u>Harford Co. 3-3-57</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5 Mar. 57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>RD. 2 Aberdeen, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Garrison Aberdeen, Md.</u> 24a. REC'D BY REGISTRAR <u>Mar 4-57</u> 24b. REGISTRAR'S SIGNATURE <u>Thelma R Perry</u>	

MEDICAL CERTIFICATION

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 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02947

CERTIFICATE OF DEATH

02950

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>328 5th St 32 BELAIR</u>	
c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		d. STREET ADDRESS <u>109 ALICE ANN ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>—</u> Last <u>BANKS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/1906</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>HARFORD COUNTY, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT SMART</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>217-24-8654</u>	
17. INFORMANT <u>Box 141, RT 2</u> <u>WHITTINGTON, ADDIE BELAIR, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Glomerulonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 18</u> , 19 <u>57</u> , to <u>MARCH 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 22</u> , 19 <u>57</u> , and that death occurred at <u>3:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St. Havre de Grace Md</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>3/22/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>MAR 24/57</u>	<u>Community Baptist</u>	<u>Jappa Route 7 Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Foster Belair Md</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 28 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Dr. R. L. Lewis</u>	

BUREAU V. S.

MAR 28 1957

RECEIVED

02970 CERTIFICATE OF DEATH

Reg. Dist. No. 182-

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Rural				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frances Hince, Nursing Home.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS Rt. 222							
3. NAME OF DECEASED (Type or print) First Blanche Middle A. Last BLACKBURN				4. DATE OF DEATH Month 3 Day 31 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1880	
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months 31 Days 31 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James A. Blackburn				14. MOTHER'S MAIDEN NAME Marion Frizell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-14-1465			
17. INFORMANT Marion E. Blackburn, Port Deposit, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO VASCULAR DISEASE DUE TO (c) ARTERIO SCLEROSIS				INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DEBILITY DUE TO ARTERITIS OF SPINE AND AGE				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0. 11. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Port Deposit, Md.				(County) (State)			
21. I certify that I attended the deceased from March 11, 1957 , to March 31, 1957 , that I last saw the deceased alive on March 31, 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip W. Heuman M.D.				ADDRESS (Street, city or town, state) 307 HICKORY AVE			
DATE SIGNED MARCH 31/57							
PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN M.D. BEL AIR, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-3-1957		22c. NAME OF CEMETERY OR CREMATORY Hopewell		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 4-2-57	
24b. REGISTRAR'S SIGNATURE Purilla Lowwood							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 4 1957

RECEIVED

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VS. A15ME(5)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02949 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 18 (

02952

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) State Harford State Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 31	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OSCAR Middle BOND Last BOND		4. DATE OF DEATH Month March Day 25 Year 19 57	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/1929
9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months 27 Days 25 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Contracting	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Bond		14. MOTHER'S MAIDEN NAME May Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-24-7471	
17. INFORMANT Linda Bond, Aberdeen, Md. (Sister)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 922.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) aspiration of foreign body (possibly during an epileptic attack) (History of fits) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspirated ball of tin foil	
20c. TIME OF INJURY Month, Day, Year Hour Unknown o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Aberdeen Harford Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen, RD, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR Mar. 27-57		24b. REGISTRAR'S SIGNATURE Nellie R. Penny	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON OFFICIAL MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		10/15/57	
Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation	
Boston, Mass.		Boston, Mass.		Heart Disease		Natural		Teacher	
Physician		Medical Examiner		Hospital		Burial Place		Burial Date	
Dr. Smith		Dr. Jones		St. Mary's		Catholic		10/20/57	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED

BUREAU V. S.

MAR 29 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02949

CERTIFICATE OF DEATH

02953

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>		d. STREET ADDRESS <u>1 TOLL Gate Vale Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> <u>Boy</u> <u>Brewer</u>				4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/3/57</u>	9. AGE (In years lost birthday) yrs. <u>9</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min. <u>9</u>	IF UNDER 24 HRS. Hours <u>9</u> Min. <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Eugene Brewer</u>				14. MOTHER'S MAIDEN NAME <u>Darlene L. Post</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>William Brewer, Bel Air, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia, post operative</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>operative</u> DUE TO (c) <u>operative</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atresia of pyloric sphincter (at operation)</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4th Mar, 1957</u> to <u>3-12</u> , 1957, that I lost saw the deceased alive on <u>3-12</u> , 1957, and that death occurred at <u>Harford</u> , Md., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. K. Brendle</u> M.D.				ADDRESS (Street, city or town, state) <u>Harre de Grace Md.</u>			
PHYSICIAN'S NAME (Type) <u>William K. Brendle</u>				DATE SIGNED <u>3/13/1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u>				ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-19-57</u>	
24b. REGISTRAR'S SIGNATURE <u>G. L. Smith Md.</u>							

2071172XV5

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
PLACE OF BIRTH [Faint handwritten place]		DATE OF BIRTH [Faint handwritten date]		PLACE OF DEATH [Faint handwritten place]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF INTERMENT [Faint handwritten place]	
SIGNATURE OF DECEASED [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]		SIGNATURE OF PHYSICIAN [Faint handwritten signature]	
SIGNATURE OF CLERK [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF JUDGE [Faint handwritten signature]	

BUREAU V. B.

MAR 20 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02971 CERTIFICATE OF DEATH

02954

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Abingdon Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				d. STREET ADDRESS Route #40			
3. NAME OF DECEASED (Type or print) First Iris Middle June Last Brown				4. DATE OF DEATH Month March Day 11 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/23/24	
9. AGE (In years last birthday) 32 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Shelby Lewis			
14. MOTHER'S MAIDEN NAME Pearl Stacy				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. ---				17. INFORMANT Husband Address As in 2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Astrocytoma, left frontal cerebrum 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Approx 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abcess of peritonsillar tissue							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. 11. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from March 5 , 19 57 , to March 11 , 19 57 , that I last saw the deceased alive on March 11 , 19 57 , and that death occurred at 9:40p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin J Crotty				ADDRESS (Street, city or town, state) US Army Hospital			
PHYSICIAN'S NAME (Type) Martin J Crotty, Capt, MC				DATE SIGNED 12 March 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/57		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gdn		22d. LOCATION (City, town, or county) (State) Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Oscar H Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Mar 13-57	
				24b. REGISTRAR'S SIGNATURE Nellie R Perry			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]		9. RELIGION [Illegible]		10. EDUCATION [Illegible]		11. SOCIAL SECURITY NUMBER [Illegible]		12. DATE OF DEATH [Illegible]	
13. PLACE OF DEATH [Illegible]		14. CAUSE OF DEATH [Illegible]		15. MANNER OF DEATH [Illegible]		16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF PHYSICIAN [Illegible]	
19. SIGNATURE OF REGISTRAR [Illegible]		20. DATE OF REGISTRATION [Illegible]		21. PLACE OF REGISTRATION [Illegible]		22. SIGNATURE OF CLERK [Illegible]		23. DATE OF ENTRY [Illegible]		24. PLACE OF ENTRY [Illegible]	

BUREAU V. 3

MAR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02972

CERTIFICATE OF DEATH

02955

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WHITEFORD				c. LENGTH OF STAY IN 1b 60 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 RURAL - WHITEFORD			
				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELMER HOLLINGSWORTH BULL				4. DATE OF DEATH Month Day Year MAR. 26, 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 2, 1867	9. AGE (In years (thday) yrs.) 89	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY Food + Dry Goods		11. BIRTHPLACE (State or foreign country) HARFORD Co., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN E. BULL				14. MOTHER'S MAIDEN NAME CORNELIA HOLLINGSWORTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address MRS. JAMES TRACEY, WHITEFORD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Idiopathic						INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 23, 1952 to March 26, 1957 , that I last saw the deceased alive on March 25, 1957 , and that death occurred at 9:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles A. Neff, M.D. Street, Maryland 3-29-57 ACTUAL SIGNATURE CHARLES A. NEFF M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-29-57		22c. NAME OF CEMETERY OR CREMATORY DEER CREEK		22d. LOCATION (City, town, or county) (State) HARFORD Co., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa.				24a. REC'D BY REGISTRAR DATE 3-30-57		24b. REGISTRAR'S SIGNATURE Willa forward	

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other vital statistics. The text is mirrored and difficult to read.

BUREAU V. S.

APR 2

RECEIVED

02973

CERTIFICATE OF DEATH

02956

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford 180			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa				c. LENGTH OF STAY IN 1b 37 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Delaney Last Carmen				4. DATE OF DEATH Month Mar. Day 15 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 28, 1898	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst., Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Electric, U.S. Govt., New York		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Ross Carmen				14. MOTHER'S MAIDEN NAME Martha Mc Knight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WW 1		16. SOCIAL SECURITY NO. 220-20-7369		17. INFORMANT Naomi H. Carmen, Joppa, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 54 , 19____, to March 15 , 19 57 , that I last saw the deceased alive on March 15 , 19 57 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Fred O. Hodous M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED 3-16-57	
PHYSICIAN'S NAME (Type) Fred O. Hodous				Edgewood, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Joppa, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Thomas & Son				ADDRESS Abingdon Maryland.		24a. REC'D BY REGISTRAR Mar 17, 1957	
				24b. REGISTRAR'S SIGNATURE Norma G. Moore			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14-00000-STATE OF CALIFORNIA

MAR 19 1957

RECEIVED
MAY 19 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02974

CERTIFICATE OF DEATH

02957

Reg. Dist. No.

181

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Tennessee b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trenton 79X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				d. STREET ADDRESS 923 College Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BUFF Middle - Last CHISOLM JR				4. DATE OF DEATH Month March Day 15 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 29, 1920		9. AGE (In years lost birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier - CWO		10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Buff Chisolm				14. MOTHER'S MAIDEN NAME Kresenburg (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW II		17. INFORMANT Official US Army Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction - secondary to 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 days						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 9 , 19 57 , to March 15 , 19 57 , that I last saw the deceased alive on March 15 , 19 57 , and that death occurred at 9:40a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William M. Michener M.D. US Army Hospital March 15, 1957 PHYSICIAN'S NAME (Type) WILLIAM M. MICHENER, Capt, MC Aberdeen Proving Ground, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		3/18/57		HUNT. TERRACE		MD	
23. FUNERAL DIRECTOR'S SIGNATURE Oscar Farring ADDRESS Aberdeen, Md				24a. REC'D BY REGISTRAR Mar 18-57		24b. REGISTRAR'S SIGNATURE Mellie P. Perry	

BUREAU

1957 20 84

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MEDICAL CERTIFICATION

02950		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		02958	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
Reg. Dist. No. 180					
1. PLACE OF DEATH a. COUNTY <u>Harford County</u> <u>Abingdon</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>40 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>B</u> Middle <u>Cook</u> Last			4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>57</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20, 1897</u>	9. AGE (In years last birthday) <u>59 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>Thomas J. Cook</u>			14. MOTHER'S MAIDEN NAME <u>Mrs. John C. Victoria Reedy</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>162-05-5893</u>		17. INFORMANT <u>Mrs. John B. Cook</u> Address <u>Abingdon, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Harford Co.</u> <u>3-20-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 22, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Center</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McComas & Son</u>		ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR <u>Mar 23, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>	
22d. LOCATION (City, town, or county) (State) <u>Forest Hill, Harford, Md.</u>					

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MA 02111
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 29 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 180

02959

02975

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i>	c. LENGTH OF STAY IN 1b <i>10 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>56 Battle St.</i>		d. STREET ADDRESS <i>1 56 Battle St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Edna C. Davis</i>		4. DATE OF DEATH Month <i>3</i> Day <i>31</i> Year <i>19 57</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-30-1900</i>
9. AGE (In years last birthday) <i>56</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Kalmar, Md.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>George E. Williams</i>		14. MOTHER'S MAIDEN NAME <i>Harriett R. Collins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-32-4584</i>	17. INFORMANT <i>Mrs. Alice C. Haeton - Edgewood, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>171X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastatic Carcinoma of the Cervix</i> DUE TO (c) <i>Metastatic Carcinoma of the Cervix</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March 10</i> , 19 <i>57</i> , to <i>March 31</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>March 31</i> , 19 <i>57</i> , and that death occurred at <i>6:50p</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>569 Revolution St., Harrede Grace, Md</i> DATE SIGNED <i>4/2/57</i>			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		M.D. <i>569 Revolution St., Harrede Grace, Md</i>	
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-4-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Clarks Chapel Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Kalmar - Harford Co. - Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock - Harrede Grace, Md.</i>		24a. REC'D BY REGISTRAR <i>Apr. 4, 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Norma E. Koss</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF DEATH <i>April 5, 1957</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>		<p>EDUCATION <i>High School</i></p>	
<p>DATE OF BIRTH <i>March 10, 1912</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>DATE OF DEATH <i>April 5, 1957</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>		<p>EDUCATION <i>High School</i></p>	
<p>DATE OF BIRTH <i>March 10, 1912</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>OCCUPATION <i>Teacher</i></p>	

BUREAU V. 2

APR 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For burial, cremation, or removal, see the instructions on the back of this form. File pages 1 and 2 with the registrar prior to funeral, cremation, or removal.

VS. A15ME(5)
5M 9/55

02976 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02960
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 181

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Nuttie Ave</u>		d. STREET ADDRESS <u>Nuttie Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Pierce W Dobson</u>		4. DATE OF DEATH <u>March 5 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13 1918</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willie Park Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Glean Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Current</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Quartermaster 7080 Aberdeen Proving Gr.</u>		Address <u>md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.S.W. Left Chest</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause lost. DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>	
20c. TIME OF INJURY Month, Day, Year <u>3-5-57</u> Hour o. m. <u>2</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dorrell C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gorrie C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>Harford Co</u>		DATE SIGNED <u>3-5-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jay Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Jay Santa Rosa Co Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Volter E. Garrison</u>		ADDRESS <u>Aberdeen Maryland</u>	
24a. REC'D BY REGISTRAR <u>March 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R. Perry</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 DEPT. OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>March 7, 1957</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		OCCUPATION <i>Teacher</i>	
BIRTH DATE <i>March 10, 1912</i>		BIRTH PLACE <i>St. Louis, Mo.</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>	
CITY OF RESIDENCE <i>Baltimore, Md.</i>		HOMERESIDENCE <i>1234 Elm St.</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>	
IMMEDIATE CAUSE <i>Coronary Thrombosis</i>		FUNDAMENTAL CAUSE <i>Arteriosclerosis</i>	
PRE-EXISTING DISEASES <i>Hypertension</i>		OTHER CAUSES <i>None</i>	
SIGNS AND SYMPTOMS <i>Severe chest pain, sweating, nausea</i>		TREATMENT <i>Aspirin, Morphine</i>	
HISTORY <i>Onset of pain at 10:00 AM, March 7, 1957</i>		FAMILY HISTORY <i>None</i>	
PHYSICAL EXAMINATION <i>Normal</i>		LABORATORY EXAMINATIONS <i>None</i>	
POST-MORTEM EXAMINATION <i>None</i>		SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
SIGNATURE OF MEDICAL EXAMINER <i>Dr. J. K. Smith</i>		OFFICIAL SEAL <i>None</i>	

BUREAU FILE

MAR 8 1957

RECEIVED

02951 CERTIFICATE OF DEATH

Reg. Dist. No.

182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u> 03x22 ✓	
c. LENGTH OF STAY IN 1b <u>10 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Office G.C. Palmer M.D.</u>		d. STREET ADDRESS <u>Reynolds Road</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>Douglas</u> Last <u>S.</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 19, 1913</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13. FATHER'S NAME <u>RAIPH O. DOUGLAS</u>		14. MOTHER'S MAIDEN NAME <u>HAZEL LISK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-01-6864</u>	
17. INFORMANT <u>Mrs. ANNAL. Douglas</u>		Address <u>REYNOLDS RD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>1-1-55</u> , 19____, to <u>3-17-57</u> 19____, that I last saw the deceased alive on <u>3-17</u> , 19 <u>57</u> , and that death occurred at <u>DA</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.	ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>3-17-57</u>
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MARCH 20, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FRANKLINVILLE-Presbyterian (M)</u>	22d. LOCATION (City, town, or county) (State) <u>FRANKLINVILLE Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassalam Funeral Home</u>	ADDRESS <u>7401 BELAIR RD.</u>	24a. REC'D BY REGISTRAR <u>AR 19 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Quella Forward</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 19 1957

RECEIVED

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 14 1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
APRIL 4 1968		MEMPHIS, TENNESSEE		SHOOTING	
OCCUPATION		EDUCATION		MARRIAGE	
MEMBER OF ARMY		HIGH SCHOOL		MARRIED	
RELIGION		SIGNED BY		WITNESSES	
METHODIST		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4 1968		APRIL 4 1968		APRIL 4 1968	

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02962

02977

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>HARFORD</u>	
CITY OR TOWN <u>Emmorton</u>		LENGTH OF STAY (in this place) <u>63 years</u>		CITY OR TOWN <u>Emmorton, Maryland</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>Wheel Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNIE</u> (Middle) <u>A.</u> (Last) <u>ELY</u>				(Month) <u>3</u> (Day) <u>9</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Nov. 18, 1867</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ISAAC Temple</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN MOORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Mrs. Nellie V. Morlok, Bel Air RD3, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				<u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease with</u>				<u>2 7 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>hypertension</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>0</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 2</u> , 19 <u>57</u> , to <u>March 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-9</u> , 19 <u>57</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Jul O Hodous</u> M.D.				ADDRESS (Street, city, town, state) <u>Edgewood Md</u> DATE SIGNED <u>3-10-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Mar. 12, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		LOCATION (City, town, or county) (State) <u>Fountain Green, Harf. Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Marilla Howard</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Foster, Bel Air, Md.</u>			
DATE <u>3-11-57</u>							

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

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39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWER

BUREAU V. S.

MAR 12 1957

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02952

CERTIFICATE OF DEATH

02963

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY MARYLAND <i>Harford Co.</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Lancaster			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harrods Grove</i>			c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lancaster 75X-3</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>21 N. Plum Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lillie</i> Middle <i>D.</i> Last <i>Erisman</i>				4. DATE OF DEATH Month <i>March</i> Day <i>21st</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 1st. 1888</i>	
9. AGE (In years lost birthday) yrs. <i>68</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Hartsough</i>				14. MOTHER'S MAIDEN NAME <i>Mary Edwards</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <i>Mrs. Paul R. Messersmith</i>		Address <i>Aberdeen, Md. #62 Swan St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Haemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterial Hypertension</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>7 Days</i> <i>5 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Heart Disease, Auricular Fibrillation</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-14-</i> , 19 <i>57</i> , to <i>3-21-</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>21 March 1957</i> , and that death occurred at <i>130 P. M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Peter P. Rodman</i>		M.D. <i>M.D.</i>		ADDRESS (Street, city or town, state) <i>8 Law St. Aberdeen, Md.</i>		DATE SIGNED <i>3-21-57</i>	
PHYSICIAN'S NAME (Type) <i>Peter P. Rodman</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/25/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Millersville Mennonite</i>		22d. LOCATION (City, town, or county) (State) <i>Millersville, Penna.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarrington</i>		ADDRESS <i>Aberdeen, Maryland.</i>		24a. REC'D BY REGISTRAR DATE <i>Mar 24-57</i>		24b. REGISTRAR'S SIGNATURE <i>A. L. Lewis M.D.</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

and the law

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1912		Maryland		Baltimore		Maryland		United States	
RACE		COLOR		RELIGION		MARRIAGE		OCCUPATION		EDUCATION		SCHOOLING		SPECIAL TRAINING	
White		White		Roman Catholic		Married		Carpenter		High School		None		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
March 26, 1957		Baltimore, Maryland		Heart Disease		Natural		Hospital		Hospital		Hospital		Hospital	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. 3

MAR 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. The pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02964
Item 18 Film 212 5-10-57 ams										02953
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 185-
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenside 75x-3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital					d. STREET ADDRESS 2229 Oakdale Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First ROBERT		Middle H.		Last GRAND		4. DATE OF DEATH Month March Day 6 Year 1957		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 13, 1915		9. AGE (In years last birthday) 40 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacture Agent		10b. KIND OF BUSINESS OR INDUSTRY Air Control		11. BIRTHPLACE (State or foreign country) Pa			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Raymond D. Grand					14. MOTHER'S MAIDEN NAME Elaine Spahr					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -		17. INFORMANT Muriel Goss Grand 2229 Oakdale Ave Glenside, Pa						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE William V. Lovitt, Jr. M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 3/6/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-57		22c. NAME OF CEMETERY OR CREMATORY Hillside		22d. LOCATION (City, town, or county) (State) Gs. Roslyn, Pa. (MONTGOMERY)				
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell					ADDRESS Harford, Md.		24a. REC'D BY REGISTRAR DATE 3-10-57		24b. REGISTRAR'S SIGNATURE G. L. Lewis m.c.	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name		National	
Place of Birth		Place of Birth	
Date of Birth		Date of Birth	
Sex		Sex	
Race		Race	
Occupation		Occupation	
Cause of Death		Cause of Death	
Manner of Death		Manner of Death	
Signature of Medical Examiner		Signature of Medical Examiner	

~~James P. K.~~

~~[Signature]~~

X

BUREAU V. B.

MAR 12 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02965

02978

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Forest Hill</u>		LENGTH OF STAY (in this place) <u>11 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
3. NAME OF DECEASED (First) (Middle) (Last) <u>Nellie</u> <u>Bly</u> <u>Hinegardner</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>21</u> <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-24-98</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>EARL HINEGARDNER, Forest Hill, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
156.1 IMMEDIATE CAUSE (A) <u>Cancer of liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 11, 1955</u> , to <u>March 21, 1957</u> , that I last saw the deceased alive on <u>March 21, 1957</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>3-22-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-25-57</u>		NAME OF CEMETERY OR CREMATORY <u>SLATEVILLE</u>		LOCATION (City, town, or county) (State) <u>DELTA, PA.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>3-26-57</u>							

CERTIFICATE OF DEATH

1. Name of deceased: **JOHN J. HARRIS**

2. Date of death: **12-15-1956**

3. Place of death: **Home**

4. Age at death: **78**

5. Sex: **Male**

6. Race: **White**

7. Marital status: **Married**

8. Occupation: **Retired**

9. Cause of death: **Heart Disease**

10. Manner of death: **Natural**

11. Date of burial: **12-18-1956**

12. Place of burial: **Catholic Cemetery**

13. Name of physician: **Dr. J. H. Smith**

14. Name of funeral home: **St. John's**

15. Signature of physician: *[Signature]*

16. Signature of funeral home: *[Signature]*

17. Name of registrar: **J. H. Smith**

18. Date of registration: **12-16-1956**

BUREAU V. 2

MAR 28 1957

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NOTATION TO REGISTRAR: This certificate is to be filed in the death records of the State Department of Health, Baltimore, Maryland. It is to be kept in the files of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be kept in the files of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be kept in the files of the Registrar of the State Department of Health, Baltimore, Maryland.

02954

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE 24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 727 MORRISON RD.				d. STREET ADDRESS 727 MORRISON RD.			
3. NAME OF DECEASED (Type or print) First RICHARD Middle OLIVER Last JACKSON				4. DATE OF DEATH Month MAR. Day 30 Year 1957			
5. SEX MALE		6. COLOR OR RACE BLACK		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 18, 1885	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - Stationary Engineer		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OLIVER JACKSON				14. MOTHER'S MAIDEN NAME SARAH EMMA BECK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 332X		17. INFORMANT George T. Stansbury			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 10, 1951 , to March 30, 1957 , that I last saw the deceased alive on March 30, 1957 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE George T. Stansbury				ADDRESS (Street, city or town, state) 569 Revolution St., Havre de Grace, Md.			
DATE SIGNED 4/2/57				DATE SIGNED 4/2/57			
PHYSICIAN'S NAME (Type) George T. Stansbury				ADDRESS HAVRE DE GRACE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-3-1957		22c. NAME OF CEMETERY OR CREMATORY ST. JAVIES		22d. LOCATION (City, town, or county) (State) HAVRE DE GRACE HARFORD, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 4-3-57	
24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 7 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02955

CERTIFICATE OF DEATH

02967

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN lb <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mollie C. James</u>		4. DATE OF DEATH <u>March 29 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Nov. 27, 1861</u>	9. AGE (In years last birthday) <u>95</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>George B. James</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Sarah E. Keithley</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Miss Thelma E. James, 538 S. Phila. Blvd. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1, 1956</u> to <u>3-29, 1957</u> , that I last saw the deceased alive on <u>3-28-57</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		DATE SIGNED <u>3-29-57</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>		ADDRESS (Street, city or town, state) <u>Bel Air, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 1, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel M.E.</u>	22d. LOCATION (City, town, or county) (State) <u>Churchville, Harf. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Foster, Bel Air, Md.</u>		24a. REC'D BY REGISTRAR <u>3-30-57</u> 24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 2 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD				c. LENGTH OF STAY IN 1b 6 WKS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS WHITEFORD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last TRULEN H. KEGLEY				4. DATE OF DEATH Month Day Year MAR. 15, 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 8, 1920		9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE		11. BIRTHPLACE (State or foreign country) ATKINS, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EMMETT KEGLEY				14. MOTHER'S MAIDEN NAME MARY E. CRIGGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MRS. RUDY I. KEGLEY, WHITEFORD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute Coracoe Decompensation DUE TO (b) Hypertensive C-V Disease (Essential) DUE TO (c) 3 1/4 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 15, 1957 , to March 15, 1957 , that I last saw the deceased alive on March 15, 1957 , and that death occurred at 4:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Denish A. Hunt M.D.				ADDRESS (Street, city or town, state) Delata Pa. DATE SIGNED 3/12/57			
PHYSICIAN'S NAME (Type) Denish A. Hunt, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-20-57		22c. NAME OF CEMETERY OR CREMATORY BELAIR GARDENS		22d. LOCATION (City, town, or county) (State) BELAIR, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins ADDRESS Delata, Pa.				24a. REC'D BY REGISTRAR DATE 3-19-57		24b. REGISTRAR'S SIGNATURE Priscilla Lowwood	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

MAR 21 1957

RECEIVED

02956 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02969

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford & Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>99 P.O.A. - Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>1310 Old Post Road</u>	
3. NAME OF DECEASED (Type or print) First <u>B</u> Middle <u>Roy</u> Last <u>Killian</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 February 30</u>
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physicist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S Govt. APG.</u>	
11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Brant David Killian</u>		14. MOTHER'S MAIDEN NAME <u>Mary (May) Ashby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1953--1955 521 36 3382</u>	
17. INFORMANT <u>Mrs. Barbara Killian</u>		Address <u>310 Old Post Rd. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, compound, comminuted</u> 810X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a), stating the underlying cause last. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Autos accident, auto-train type</u>	
20c. TIME OF INJURY Month, Day, Year <u>3-9-57</u> Hour <u>3</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Penn RR Tracks</u>	20f. (City or town) (County) (State) <u>Aberdeen Hartford Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
<u>Bel Air, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Hartford County</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>3/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Denver Colo.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harrington</u>		ADDRESS <u>Aberdeen, Md.</u>	24a. REC'D BY REGISTRAR <u>Mar 11-57</u>
		24b. REGISTRAR'S SIGNATURE <u>Nellie R. Pliny</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG212 3-28-57 et

CERTIFICATE OF DEATH

02970-

Reg. Dist. No. 186

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	c. LENGTH OF STAY IN 1b <u>11 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Long Point Harbor</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>[redacted]</u> Last <u>Kolarik</u>	4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 11, 1903</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe</u>	11. BIRTHPLACE (State or foreign country) <u>Czech.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>LOUISE KOLARIK</u>		14. MOTHER'S MAIDEN NAME <u>FRANCISCO WITEK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>215-18-3679</u>	17. INFORMANT Address <u>Bozena Kolarik, Abingdon Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180X METASTATIC CARCINOMA OF LUNGS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERNEPHROMA OF LEFT KIDNEY</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>55</u> , to <u>March 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-16</u> , 19 <u>57</u> , and that death occurred at <u>3:16 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Beulah D. Hay</u>		ADDRESS (Street, city or town, state) <u>HARRE DE GRACE MD.</u> DATE SIGNED <u>3-16-57</u>	
PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u>		<u>HARRE DE GRACE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 19, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>	22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u>		24a. REC'D BY REGISTRAR DATE <u>Mar. 20-57</u>	
ADDRESS <u>Abingdon, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>G. D. Lewis md.</u>	

CERTIFICATE OF DEATH

File No. 11

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BUREAU V. 2

MAR 21 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02971

02958

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Havre De Grace</u>		<u>25 yrs.</u>		TOWN <u>Rural--Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u> <u>Havre De Grace, Md.</u>				STREET ADDRESS (If rural give location) <u>Route # 1 ---Hickory</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LAMA</u> (Middle) <u>S</u> (Last) <u>MARTIN SR</u>				(Month) <u>March</u> (Day) <u>27</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Wh.</u>	<u>Married</u>	<u>Jan 15-1898</u>	<u>59</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farmer</u>		<u>N. Carolina</u>		<u>US</u>	
13. FATHER'S NAME <u>JAMES SMARTIN</u>				14. MOTHER'S MAIDEN NAME <u>MYRTLE MARTIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>215-32-2618</u>		<u>Lama S Martin SR RockSpring Rd Bel Air Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
177X IMMEDIATE CAUSE (A) <u>Generalized metastases (carcinomatous)</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Carcinoma of Prostate (inoperable)</u>							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 20</u> , 19 <u>56</u> , to <u>Mar. 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar. 26</u> , 19 <u>57</u> , and that death occurred at <u>10 A</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Md</u>			
DATE <u>3-27-57</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>MAR 30 1957</u>		<u>Bel Air Memorial</u>		<u>Bel Air, Harford Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>MAR 29 1957</u>		<u>Dr. H. L. Lewis</u>		<u>Joseph T. Foster</u>			

CERTIFICATE OF DEATH

Form No. 10-1-54

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Write)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. DATE OF DEATH (Month, Day, Year)

9. TIME OF DEATH (Hour, Minute)

10. PLACE OF DEATH (City, State, Country)

11. CAUSE OF DEATH (Print or Write)

12. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide)

13. SIGNATURE OF PHYSICIAN (Print or Write)

14. SIGNATURE OF REGISTRAR (Print or Write)

15. SIGNATURE OF WITNESS (Print or Write)

16. SIGNATURE OF DECEASED (Print or Write)

17. SIGNATURE OF NEXT OF KIN (Print or Write)

18. SIGNATURE OF CLERK (Print or Write)

19. SIGNATURE OF CHURCH CLERK (Print or Write)

20. SIGNATURE OF BURIAL CLERK (Print or Write)

21. SIGNATURE OF INTERMENT CLERK (Print or Write)

22. SIGNATURE OF CREMATION CLERK (Print or Write)

23. SIGNATURE OF OTHER CLERK (Print or Write)

24. SIGNATURE OF OTHER CLERK (Print or Write)

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40. SIGNATURE OF OTHER CLERK (Print or Write)

BUREAU V. H.

MAR 29 1957

RECEIVED

NOTATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02972

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. LENGTH OF STAY IN 1b 1 hr.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Perryman			
				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle James Last McGuigan				4. DATE OF DEATH Month March Day 26 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/4/1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) manager				10b. KIND OF BUSINESS OR INDUSTRY Harford Co. Dispensaries			
11. BIRTHPLACE (State or foreign country) Darlington, Md				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Sylvester A. McGuigan				14. MOTHER'S MAIDEN NAME Margaret Keating			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Mrs. Margaret Keating				Address Mrs. Margaret Keating, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) Myocardial infarct							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/29/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Ever	
22d. LOCATION (City, town, or county) (State) Tolome de Grace, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Perryman & Son, Tolome de Grace Md				24a. REC'D BY REGISTRAR DATE 3-28-57		24b. REGISTRAR'S SIGNATURE G. L. Lewis	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALLIANCE STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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182

BUREAU V. S.

MAR 29 1957

RECEIVED

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02960

CERTIFICATE OF DEATH

02973

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Hartore de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 2</u>		d. STREET ADDRESS <u>RD 2</u>	
3. NAME OF DECEASED (Type or print) <u>Charles S. Mitchell</u>		4. DATE OF DEATH <u>March 15 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 25, 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin W. Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Florence Swartz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>RD. 2</u>	
17. INFORMANT <u>ARMFIELD MITCHELL</u>		Address <u>Hartford Grace, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>57</u> to <u>3-15</u> , 19 <u>57</u> that I last saw the deceased alive on <u>3-14</u> , 19 <u>57</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-15-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CALVERY CEM</u>	22d. LOCATION (City, town, or county) (State) <u>HARTFORD CO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell, Hartford Grace, MD</u>		24a. REC'D BY REGISTRAR <u>DATE Mar 18. 57</u>	24b. REGISTRAR'S SIGNATURE <u>Bertha B. Knight</u>

CERTIFICATE OF DEATH

NAME OF DECEASED MARTIN		AGE 25		SEX M		RACE W		DATE OF BIRTH 1932		PLACE OF BIRTH BALTIMORE	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		DISEASE OR INJURY CORONARY ARTERY DISEASE		PERIOD OF ILLNESS 2 WEEKS		PLACE OF DEATH HOME	
DATE OF DEATH MAY 15 1957		TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME		NAME OF PHYSICIAN DR. J. H. SMITH		NAME OF HOSPITAL BALTIMORE HOSPITAL		NAME OF NURSE MISS J. BROWN	
NAME OF WITNESS DR. J. H. SMITH		SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF WITNESS J. H. SMITH		SIGNATURE OF DECEASED MARTIN		SIGNATURE OF NEXT OF KIN MRS. J. H. SMITH		SIGNATURE OF BURIAL OFFICIAL BALTIMORE BOARD OF HEALTH	
DATE OF BURIAL MAY 17 1957		PLACE OF BURIAL BALTIMORE CEMETERY		NAME OF BURIAL OFFICIAL BALTIMORE BOARD OF HEALTH		NAME OF MINISTER REV. J. H. SMITH		NAME OF CHURCH BALTIMORE CHURCH		NAME OF FUNERAL HOME BALTIMORE FUNERAL HOME	

BUREAU V. 2

MAR 22 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

02974

Reg. Dist. No. 182

02980

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Hartford</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Hartford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reckord Rural</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reckord Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Ricca</u> (Middle) <u>Steitz</u> (Last) <u>Moore</u>		(Month) <u>Mar</u> (Day) <u>26</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept 12/1874</u>
		9. AGE last birthday <u>82</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>HENRY Steitz</u>		14. MOTHER'S MAIDEN NAME <u>Amelia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
		17. INFORMANT & ADDRESS <u>Herbert Moore</u> <u>Steger MD Box 120</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
260X IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>			<u>20 min.</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes Mellitus</u>			<u>30 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Permeious</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Permeious Anaemia</u>			<u>10 yrs</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED	
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/18</u> , 19 <u>46</u> , to <u>3/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/24</u> , 19 <u>57</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.			
SIGNATURE <u>Clifford F. Hudson</u>		DATE SIGNED <u>3/27/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Mar 29/57</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Belone</u>		26. ADDRESS (Street, city, town, state) <u>Fork, Md.</u>	
27. DATE <u>3-27-57</u>		28. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>	
29. DATE <u>3-27-57</u>		30. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>	

CERTIFICATE OF DEATH

1. Name of deceased (Print or write full name)

2. Date of death

3. Place of death

4. Age

5. Sex

6. Race

7. Occupation

8. Cause of death

9. Duration of illness

10. Name of physician

11. Name of funeral director

12. Name of informant

13. Address of deceased

14. Address of informant

15. Address of funeral home

16. Address of cemetery

17. Name of hospital

18. Name of doctor

19. Name of nurse

20. Name of undertaker

21. Name of registrar

22. Name of coroner

23. Name of judge

24. Name of clerk

25. Name of witness

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BUREAU V. 3

MAR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02961

CERTIFICATE OF DEATH

Reg. Dist. No.

02975

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Abendeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>411 Edmund</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Morgan</u> Last <u>Morgan</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? 1900</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>4</u> Hours <u>24</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dish washer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS MORGAN</u>		14. MOTHER'S MAIDEN NAME <u>Josie Talbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-0816</u>	
17. INFORMANT <u>Mr. Gustave G. Quarles - Washington, D.C.</u>		Address <u>515 - 5th St. S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pleurisy with Effusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition (Severe)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>57</u> , to <u>3/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/6</u> , 19 <u>57</u> , and that death occurred at <u>6:59 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St. Havre de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>3/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>3/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer T. Bulluck</u>		ADDRESS <u>Havre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>Mar. 7-57</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Lewis</u>	

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02976

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				d. STREET ADDRESS 24 Aberdeen Ave			
3. NAME OF DECEASED (Type or print) First LONA Middle SUE Last MUNSON				4. DATE OF DEATH Month March Day 6 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1957		9. AGE (In years last birthday) yrs. 42	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Emerson Munson				14. MOTHER'S MAIDEN NAME Rhoda Evelyn Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father		Address Same as in 2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable congenital abnormality 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 42	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 19 p. m. Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 6 , 19 57 , to March 6 , 19 57 , that I last saw the deceased alive on March 6 , 19 57 , and that death occurred at 1200 noon , from the causes and on the date stated above.							
ACTUAL SIGNATURE Alan C. Lakin				M.D. US Army Hospital		DATE SIGNED March 7, 1957	
PHYSICIAN'S NAME (Type) ALAN C LAKIN, Capt, MC				Aberdeen Proving Ground, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/57		22c. NAME OF CEMETERY OR CREMATORY Post Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Proving Gr. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Harving				ADDRESS Aberdeen Md.		24a. REC'D BY REGISTRAR Mar 8-57	
				24b. REGISTRAR'S SIGNATURE Nellie R Perry			

2050253xv5

BUREAU V. S.

MAR 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02977
Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Auto on Thon's Street</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>J. Williams</u> First Middle Last		4. DATE OF DEATH <u>March 29</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31/1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Damage Dept General Counsel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Alfred P. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-01-1262</u>	
17. INFORMANT <u>William Margaret & Paul</u> Address <u>Bel Air RD 3 Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Derald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Hartford</u>	
EXAMINER'S NAME (Type) <u>Bel Air Md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>County</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-29-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-12-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. ...</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>3-30-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Priscilla ...</u>	

APR 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02982

CERTIFICATE OF DEATH

02978
180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABINGDON</u>		c. LENGTH OF STAY IN 1b <u>10 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL CAMP X2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US Rt 40</u>				d. STREET ADDRESS <u>US Rt 40</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES FULLER RAY JR</u>				4. DATE OF DEATH Month Day Year <u>MARCH 2 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 9, 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MASSUEUR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TURKISH BATH</u>			
13. FATHER'S NAME <u>FRANK P. RAY</u>				14. MOTHER'S MAIDEN NAME <u>IDA A. ANGEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-14-4998</u>		17. INFORMANT <u>Charles F. Ray Jr.</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA - due to PULMONARY EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>ARTERIO SCLEROTIC CARDIO-VASCULAR Dis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS</u> <u>2 YEARS OVER 5 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV.</u> , 19 <u>55</u> , to <u>MARCH 2</u> , 19 <u>57</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.				ADDRESS (Street, city or town, state) <u>307 Hickory, BEL AIR MD</u>			
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN</u>				DATE SIGNED <u>MAR 2 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>				ADDRESS <u>4210 Belair Rd</u>		24a. RECEIVED BY REGISTRAR <u>MAR 4</u>	
				24b. REGISTRAR'S SIGNATURE <u>Norma G. Morris</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

MAR 5 1937

RECEIVED

02963

CERTIFICATE OF DEATH

02979

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <i>Harford</i> <i>Maryland</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase 24</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hosp.</i>		d. STREET ADDRESS <i>666 Green</i>	
3. NAME OF DECEASED (Type or print) <i>Chase Bruce Reynolds</i>		4. DATE OF DEATH <i>3/19/57</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/30/1882</i>
9. AGE (in years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Chase, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Stephen N. Chase</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John D. Reynolds</i>		Address <i>666 Green St. Harford Chase, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.1 DUE TO (b) <i>Arterio Sclerotic Cardio Vascular</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Hypertensive Disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 1957</i> to <i>March 1957</i> , that I last saw the deceased alive on <i>May 19, 1957</i> , and that death occurred at <i>10</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles J. Foley</i> M.D.		ADDRESS (Street, city or town, state) <i>400 S. Huron Ave. Harford Chase, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Charles J. Foley</i>		DATE SIGNED <i>3/22/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/22/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harford Chase, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Connington & Son, Harford Chase, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>DATE Mar 22-57</i>		24b. REGISTRAR'S SIGNATURE <i>A. L. Lewis M.D.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ALABAMA STATE DEPARTMENT OF HEALTH—BUREAU OF VITAL STATISTICS

BUREAU V. S.

MAR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02964

CERTIFICATE OF DEATH

02980

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>729 S Union Ave</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>H</u> Middle <u>Richardson</u> Last				4. DATE OF DEATH <u>3/17/57</u> Month <u>3</u> Day <u>17</u> Year <u>19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u> <u>1865</u> <u>93</u> yrs.	
9. AGE (In years last birthday) <u>93</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>729 S Union Ave</u> <u>Harford Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/17</u> , 19 <u>57</u> , to <u>3/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/17</u> , 19 <u>57</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u>				ADDRESS (Street, city or town, state) <u>569 Revolution St., Harford Md.</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				DATE SIGNED <u>3/19/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gravelly Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jameson</u>				24a. REC'D BY REGISTRAR <u>3-20-57</u>			
ADDRESS <u>Harford Md.</u>				24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1. FULL NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH	
6. DATE OF DEATH		7. TIME OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CLERK		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF PHYSICIAN		29. SIGNATURE OF CLERK		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF CLERK		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESS		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF CLERK		40. SIGNATURE OF REGISTRAR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESS		43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF CLERK		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESS		48. SIGNATURE OF PHYSICIAN		49. SIGNATURE OF CLERK		50. SIGNATURE OF REGISTRAR	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESS		53. SIGNATURE OF PHYSICIAN		54. SIGNATURE OF CLERK		55. SIGNATURE OF REGISTRAR	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF WITNESS		58. SIGNATURE OF PHYSICIAN		59. SIGNATURE OF CLERK		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF PHYSICIAN		64. SIGNATURE OF CLERK		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF WITNESS		68. SIGNATURE OF PHYSICIAN		69. SIGNATURE OF CLERK		70. SIGNATURE OF REGISTRAR	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESS		73. SIGNATURE OF PHYSICIAN		74. SIGNATURE OF CLERK		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESS		78. SIGNATURE OF PHYSICIAN		79. SIGNATURE OF CLERK		80. SIGNATURE OF REGISTRAR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESS		83. SIGNATURE OF PHYSICIAN		84. SIGNATURE OF CLERK		85. SIGNATURE OF REGISTRAR	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF WITNESS		88. SIGNATURE OF PHYSICIAN		89. SIGNATURE OF CLERK		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS		93. SIGNATURE OF PHYSICIAN		94. SIGNATURE OF CLERK		95. SIGNATURE OF REGISTRAR	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF WITNESS		98. SIGNATURE OF PHYSICIAN		99. SIGNATURE OF CLERK		100. SIGNATURE OF REGISTRAR	

BUREAU V. 1

MAR 22 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02981

CERTIFICATE OF DEATH

02983

Reg. Dist. No. 183

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Hartford</u>	
CITY OR TOWN <u>Federal Hill</u>		LENGTH OF STAY (in this place) <u>69 yrs</u>		CITY OR TOWN <u>Federal Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>Rocks Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Gda Glenn Robinson</u>				4. DATE OF DEATH <u>March 21st 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Apr. 27-1887</u>	
9. AGE last birthday <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hartford Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wesley Clay Holland</u>		14. MOTHER'S MAIDEN NAME <u>Martha Evans</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>	
16. SOCIAL SECURITY NO. <u>218-12-4189</u>		17. INFORMANT & ADDRESS <u>Sumner Clarence Robinson</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. DATE OF OPERATION			
420.1 IMMEDIATE CAUSE (A) <u>CORONARY Thrombosis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAR 19 55</u> , to <u>21 MAR 19 57</u> , that I last saw the deceased alive on <u>21 MAR 19 57</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thos. A. Mowley</u>				DATE SIGNED <u>March 21 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-24-57</u>		NAME OF CEMETERY OR CREMATORY <u>St James Cemetery</u>		LOCATION (City, town, or county) <u>Federal Hill Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Prueille A. Forwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martha Evans</u>		ADDRESS <u>7777</u>	
DATE <u>3-26-57</u>							

CERTIFICATE OF DEATH

File No.

A. FULL NAME OF DECEASED

Full Name of Deceased
Federal Hill
8-22-57

MAILED

COPIES

March 1
Federal Hill

John George K. Jones

Female

Martha Evans

18. MEDICAL CERTIFICATION

1. Cause of Death
2. Manner of Death
3. Place of Death
4. Date of Death
5. Time of Death
6. Age at Death
7. Sex
8. Race
9. Color
10. Height
11. Weight
12. Complexion
13. Eyes
14. Hair
15. Teeth
16. Ears
17. Nose
18. Mouth
19. Throat
20. Lungs
21. Heart
22. Liver
23. Stomach
24. Intestines
25. Kidneys
26. Bladder
27. Uterus
28. Vagina
29. Penis
30. Testes
31. Prostate
32. Spleen
33. Pancreas
34. Gallbladder
35. Bile Ducts
36. Salivary Glands
37. Thyroid Gland
38. Parathyroid Glands
39. Adrenal Glands
40. Pituitary Gland
41. Hypothalamus
42. Hypophysis
43. Pineal Gland
44. Optic Nerves
45. Optic Chiasm
46. Optic Tracts
47. Optic Nerves
48. Optic Chiasm
49. Optic Tracts
50. Optic Nerves

BUREAU V. 1

MAR 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02965

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02982-

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Hartford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpers Grace</u>			c. LENGTH OF STAY IN 1b <u>2 hrs</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hosp.</u>			d. STREET ADDRESS <u>11410 Paradise Rd.</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Paul Smith</u>			4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1957</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>March 31, 1919</u>		9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Paul Habala</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. #2</u>		16. SOCIAL SECURITY NO. <u>118-01-6662</u>		17. INFORMANT Address <u>Mrs. Wm. P. Shmitt 410 Paradise Rd. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G S W Cerebrum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976x</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with pistol</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> p. m. <u>3-2</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Aberdeen</u>		20g. (County) <u>Hartford</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gerald P. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-3-57</u>	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bela Air md</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Hartford Co</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5 Mar. 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cemetery</u>	
22d. LOCATION (City, town, or county) <u>R.D. Aberdeen,</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Parry</u>		ADDRESS <u>Aberdeen Md.</u>		24a. REC'D BY REGISTRAR <u>3-5-57</u>	
24b. REGISTRAR'S SIGNATURE <u>G. A. Lewis M.D.</u>					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, date of death, and cause of death. The form is partially filled out with handwritten text.

NAME: *John Doe*
AGE: *45*
SEX: *Male*
DATE OF DEATH: *March 10, 1957*
CAUSE OF DEATH: *Heart Disease*

BUREAU V. S.

MAR 7 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02983

CERTIFICATE OF DEATH

02984

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Joppa</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Joppa</i>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rural</i>				STREET ADDRESS (If rural give location) <i>Rural</i>			
3. NAME OF DECEASED (Type or Print) <i>Harriet Louis Shriver</i>				4. DATE OF DEATH <i>Mar, 11, 1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widow</i>		8. DATE OF BIRTH <i>June 12, 1873</i>	
9. AGE last birthday <i>83</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Bel Air, Md</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S</i>	
13. FATHER'S NAME <i>George L. Van Bibber</i>				14. MOTHER'S MAIDEN NAME <i>Adelle Franklin</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Rev. George Shriver -</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <i>Uremia</i>						5 days	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Cardiovascular Disease</i>						15 yrs +	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec., 1954</i> , to <i>March, 1957</i> , that I last saw the deceased alive on <i>March 9, 1957</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>William A. Tyeon</i> M.D.				DATE SIGNED <i>3-11-57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Mar. 13, 1957</i>		NAME OF CEMETERY OR CREMATORY <i>Mary's</i>		LOCATION (City, town, or county) (State) <i>Cummorton Md</i>	
24. REC'D BY REGISTRAR <i>Norma L. Money</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>W.H. Archer</i>		ADDRESS <i>Bonham Rd</i>	
DATE <i>MAR 15 1957</i>							

CERTIFICATE OF DEATH

1. DECEASED'S RESIDENCE (STREET OR BOX NUMBER)

2. PLACE OF DEATH

3. COUNTY

4. DISTRICT

5. DECEASED'S AGE

6. SEX

7. DECEASED'S OCCUPATION

8. DECEASED'S MARITAL STATUS

9. DECEASED'S RACE

10. DECEASED'S BIRTH DATE

11. DECEASED'S BIRTH PLACE

12. DECEASED'S BIRTH CERTIFICATE NUMBER

13. DECEASED'S BIRTH DATE

14. DECEASED'S BIRTH PLACE

15. DECEASED'S BIRTH CERTIFICATE NUMBER

16. DECEASED'S BIRTH DATE

17. DECEASED'S BIRTH PLACE

18. DECEASED'S BIRTH CERTIFICATE NUMBER

19. DECEASED'S BIRTH DATE

20. DECEASED'S BIRTH PLACE

21. DECEASED'S BIRTH CERTIFICATE NUMBER

22. DECEASED'S BIRTH DATE

23. DECEASED'S BIRTH PLACE

24. DECEASED'S BIRTH CERTIFICATE NUMBER

25. DECEASED'S BIRTH DATE

26. DECEASED'S BIRTH PLACE

27. DECEASED'S BIRTH CERTIFICATE NUMBER

28. DECEASED'S BIRTH DATE

29. DECEASED'S BIRTH PLACE

30. DECEASED'S BIRTH CERTIFICATE NUMBER

NOT RECORDED

BUREAU V. 1

MAR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02984

02966

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>11 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace 24</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial</u>			d. STREET ADDRESS <u>301 N. Union Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Smith</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22, 1884</u>		9. AGE (In years lost birthday) yrs. <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Richard Smith</u>			14. MOTHER'S MAIDEN NAME <u>Alice Hall Patterson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Miss Goldie Smith, Darlington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Carcinomatosis</u> DUE TO (c) <u>Cachexia</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>June 1951</u> , 19 _____, to <u>Mar 24, 1957</u> , that I last saw the deceased alive on <u>March 24</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.			ADDRESS (Street, city or town, state) <u>Harre de Grace, Md</u>		
PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u>			DATE SIGNED <u>Mar 30/57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington + Son, Harre de Grace, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>3-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis mcl.</u>

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02985

CERTIFICATE OF DEATH

02985

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pylesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pylesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edna Rosier Smithson				4. DATE OF DEATH March 11, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1898	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Rosier				14. MOTHER'S MAIDEN NAME Harriet Daily			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 168-14-3841		17. INFORMANT Richard Smithson, Fawn Grove RD, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 171X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 54 , to March 11, 1957 , that I last saw the deceased alive on March 10, 1957 , and that death occurred at 2 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fawn Grove, York Co., Penna. DATE SIGNED 3/11/57							
ACTUAL SIGNATURE Edward W. Hyson M.D.				PHYSICIAN'S NAME (Type) Edward W. Hyson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-57		22c. NAME OF CEMETERY OR CREMATORY St. Paul Meth.		22d. LOCATION (City, town, or county) (State) Pylesville, Harford Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Oshorn				ADDRESS Stewartstown, Penna.		24a. REC'D BY REGISTRAR DATE 3-13-57	
				24b. REGISTRAR'S SIGNATURE Pucilla Forward			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1912		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1957		10:00 AM		Home		J. A. Smith		M. B. Jones	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Date of Last Medical Examination		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Teacher		Married		None		Jan 10, 1957		Jan 10, 1957		Jan 15, 1957		10:00 AM		Home		J. A. Smith		M. B. Jones		J. A. Smith		M. B. Jones	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
Jan 15, 1957		10:00 AM		Home		J. A. Smith		M. B. Jones		J. A. Smith		M. B. Jones		J. A. Smith		M. B. Jones		J. A. Smith		M. B. Jones		J. A. Smith	

BUREAU V. S.

MAR 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02986

02967 CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>			c. LENGTH OF STAY IN 1b <u>31</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Asbury</u> Middle <u>—</u> Last <u>Thomās</u>			4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jay Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Unknown</u>		
14. MOTHER'S MAIDEN NAME <u>Arvine Hall</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>218-05-7939</u>			17. INFORMANT <u>John H. Bond</u> Address <u>853 Erie St Harre de Grace Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cerebral Vascular Disease</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonitis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Prostatism with Acute Retention and Mild Azotemia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>		20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Dec. 12</u> , 19 <u>52</u> , to <u>March 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 26</u> , 19 <u>57</u> , and that death occurred at <u>9:50</u> A.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>George T. Stansbury</u>		M.D. <u>569 Revolution St, Harre de Grace, Md</u>		DATE SIGNED <u>3/27/57</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		<u>HARRE DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>208 Calvary Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarring</u>		ADDRESS <u>Aberdeen Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Apr. 1-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. A. Lewis M.D.</u>

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hanford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN 1b <u>2.5 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>18</u>				d. STREET ADDRESS <u>18</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Burgiss</u> Middle <u>D</u> Last <u>Wales</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-4-1871</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.	IF UNDER 24 HRS. Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>York Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wales</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Wilbur Elder Whitey My</u> Address <u>no</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 4, 1957</u> to <u>March 7, 1957</u> , that I last saw the deceased alive on <u>March 7, 1957</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward H. Hyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Harris Shreve, Pa</u>		DATE SIGNED <u>3/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Edward H. Hyson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-10-57</u>		<u>St. Olav's</u>		<u>Harris Shreve Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Brown</u>				ADDRESS <u>Harris Shreve Pa</u>		24a. REC'D BY REGISTRAR DATE <u>3-10-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Priscilla Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the certificate form, including fields for name, date, and cause of death.]

BUREAU V. S.

MAR 18 1957

RECEIVED



CERTIFICATE OF DEATH

02987

Reg. Dist. No. 180

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgewood</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgewood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) <u>DORA</u> (Middle) <u>—</u> (Last) <u>WALTMAN</u>				4. DATE OF DEATH (Month) <u>March</u> , (Day) <u>13</u> , (Year) <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Nov. 29, 1874</u>		9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Waltman</u>				14. MOTHER'S MAIDEN NAME <u>Annie Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Jacob Waltman, Edgewood, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1 IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARDIOVASCULAR DISEASE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>NOV. 47</u> , 19 <u>47</u> , to <u>3/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. W. Stewart, Jr.</u>				ADDRESS (Street, city, town, state) <u>130X 95 EDGEWOOD, MD.</u>		DATE SIGNED <u>3/13/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 16, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>		LOCATION (City, town, or county) (State) <u>Joppa, Harford, Md.</u>	
24. REC'D BY REGISTRAR <u>March 17, 1957</u>		REGISTRAR'S SIGNATURE <u>Norma S. Moore</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard E. McComas & Son</u>			
				ADDRESS <u>Abingdon, Md.</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL

16. SIGNATURE OF CREMATION

17. SIGNATURE OF INTERMENT

18. SIGNATURE OF REINTERMENT

19. SIGNATURE OF REINTERMENT

20. SIGNATURE OF REINTERMENT

21. SIGNATURE OF REINTERMENT

22. SIGNATURE OF REINTERMENT

23. SIGNATURE OF REINTERMENT

24. SIGNATURE OF REINTERMENT

25. SIGNATURE OF REINTERMENT

BUREAU V. S.

MAR 19 1957

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ATTENTION TO RECORDS

RECORDS SECTION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

02968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02989

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover Trace</u>		c. LENGTH OF STAY IN 1b <u>1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leleura</u> Middle <u>ann</u> Last <u>Whittaker</u>				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 20 1953</u>	
9. AGE (In years last birthday) <u>2 mo.</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Bear Whittaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Name <u>Bearl Belcher</u> Address <u>Darlington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar PNEUMONIA</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>MD</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. George</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				24a. REC'D BY REGISTRAR DATE <u>April 2, 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>G. A. Lewis</u>			

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MASSACHUSETTS DEPARTMENT OF HEALTH - BAYVIEW, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF DEATH		8. OCCUPATION		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF SURGEON		15. SIGNATURE OF DENTIST		16. SIGNATURE OF MIDWIFE		17. SIGNATURE OF NURSE		18. SIGNATURE OF OTHER	

BUREAU V. S.

APR 4 1957

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MASSACHUSETTS DEPARTMENT OF HEALTH - BAYVIEW, 18

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02988

CERTIFICATE OF DEATH

02990

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, (Rural)</u>		LENGTH OF STAY (in this place) <u>11 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>RED PUMP Rd; CARICO FARM</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>LEWIS</u> (Last) <u>WINDLE</u>				(Month) <u>MAR</u> (Day) <u>2</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 4-1906</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>But Shock's Shipping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>		11. BIRTHPLACE (State or foreign country) <u>Petaluska Co. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>VA</u>	
13. FATHER'S NAME <u>JOHN WINDLE</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE WINDLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. ANNE W. WINDLE</u> <u>BEL AIR MD 5, Dillinger</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>STATUS ASTHMATICUS</u>				<u>36 HOURS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIO SCLEROTIC (CARDIO VASCULAR) DISEASE</u>				<u>OVER 5 YRS</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CARDIAC ASTHMA</u>				<u>OVER 5 YRS</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEB. 1955, to MAR 2, 1957, that I last saw the deceased alive on MAR 2, 1957, and that death occurred at 11:30 AM, from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Dorman</u>				DATE SIGNED <u>MAR 2 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>MAR 5/57</u>		NAME OF CEMETERY OR CREMATORY <u>Protestant Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bel Air MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Prueella Lownd</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Lister</u>		ADDRESS <u>Bel Air MD</u>	
DATE <u>3-3-57</u>							

BUREAU V. S.

MAR 5 1967

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